General Information for Authorization

Org	1. 511		Service Type	2. MISC

Client Information				
Name	3. CLIENT NAME		Client ID	4. 123456789WA
Living Arrangements	5. N/A		Reference Auth #	6.

Provider Information				
Requesting NPI #	7. 1123456789		Requesting Fax #	8. XXXXXXXXXX
Servicing NPI #	9. 1123456789		Name	10. SERVICING PROVIDER NAME; LABORATORY
Referring NPI #	11. 1123456789		Referring Fax #	12. XXXXXXXXXX
Service Start Date:	13.			14. N/A

Service Request Information

Description of service being requested:

15. Genetic testing		16. N/A	17. N/A
18. Serial / NEA# N/A		19. N/A	

20. Code Qualifier	21. National Code	22. Mod	23. # Units/Days Requested	24. $ Amount Requested	25. Part # (DME Only)	26. Tooth or Quad #
C	CPT		#	N/A	N/A	N/A

Medical Information				
Diagnosis Code	27. ICD-9	Diagnosis name	28. DIAGNOSIS NAME	
Place of service	29. 11			

30. Comments:

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Instructions to fill out the General Information for Authorization form, DSHS 13-835

FIELD	NAME	ACTION
		ALL FIELDS MUST BE TYPED.
1	Org required	Enter the Number that Matches the Program/Unit for the Request 500 - Division of Alcohol and Substance Abuse (DASA) 501 - Dental 502 - Durable Medical Equipment (DME) 509 - Economic Services Administration (ESA) (DSHS) 504 - Home Health 505 - Hospice 506 - Inpatient Hospital 507 - Juvenile Rehabilitation Administration (JRA) (DSHS) 508 - Medical 509 - Medical Nutrition 510 - Mental Health 511 - Outpt Proc/Diag 513 - Physical Medicine & Rehabilitation (PM & R) 514 - Aging and Disability Services Administration (ADSA) 515 - Transportation 516 - Miscellaneous
2	Service Type required	Enter the letter(s) in all CAPS that represent the service type you are requesting. AA — Ambulatory Aids BB — Bath Bench BEM — Bath Equipment (misc) BGM — Blood Glucose Monitors BGS — Bone Growth Stimulator BP — Breast Pumps BS — Bariatric surgery BSS2 — Bariatric surgery stage 2 C — Commode CI — Cochlear Implants CIERP — Cochlear Implant Ext Repl Prts CSC — Commode/Shower Chair CWN — Crowns DASA — DASA DEN — Dentures EN — Enteral Nutrition ESA — ESA FSFS — Floor Sitter/Feeder Seat HB — Hospital Beds HEA — Hearing Aids HH — Home Health HSPC — Hospice IPT — Infusion/Parental Therapy ITA — Inpatient admission - ITA JRA — JRA LTAC — LTAC MC — Medication MISC — Miscellaneous MN — Medical Nutrition MWH — Manual Wheelchair - Home MWNF — Manual Wheelchair - NF O — Other ODC — Orthodontic ODME — Other DME OOS — Out of State OP — Ostomy Products OS — Orthopedic Shoes OTC — Orthotics PAS — PAS PDN — Private Duty Nursing PHY — Pharmacy PL — Patient Lifts PMR — PM and R PROS — Prosthetics PRS — Prone Standers PSY — Psychotherapy PTL — Partial PWH — Power Wheelchair - Home PWNF — Power Wheelchair – NF PWNF — Power Wheelchair - NF PHYS — Physician Services R — Respiratory RBS — Rebases RE — Room equipment RLNS — Relines RM — Readmission S — Surgery SBS — Specialty Beds/Surfaces SC — Shower chairs SCAN — MRI/PET Scans SF — Standing Frames SGD — Speech Generating Device SSIP — Short Stay (In-Patient) T — Therapies (PT/OT/ST) TRN — Transportation TU — TENS Units US — Urinary Supplies V — Vision VNSS — Vagus nerve stimulator surgery VOL — Inpatient admission-Voluntary WDCS — Wound/decubiti care supplies

3	Name: Required.	Enter the last name, first name, and middle initial of the patient you are requesting authorization for.
4	Client ID: Required.	Enter the client ID = 9 numbers followed by WA. For Prior Authorization (PA) requests when the client ID is unknown (e.g. client eligibility pending): ■ You will need to contact DSHS at 1-800-562-3022 and the appropriate extension of the Authorization Unit (See contact section for further instructions). ■ A reference PA will be built with a placeholder client ID. ■ If the PA is approved – once the client ID is known – you will need to contact DSHS either by fax or phone with the Client ID. ■ The PA will be updated and you will be able to bill the services approved.
5	Living Arrangements	Indicate where your patient resides such as, home, group home, assisted living, skilled nursing facility, etc.
6	Reference Auth #	·If requesting a change or extension to an existing authorization, please indicate the number in this field.
7	Requesting NPI #: Required.	The 10 digit numeric number that has been assigned to the requesting provider by CMS.
8	Requesting Fax#	The fax number of the requesting provider.
9	Servicing NPI #: Required.	The 10 digit numeric number that has been assigned to the billing/servicing provider by CMS.
10	Name	The name of the billing/servicing provider.
11	Referring NPI #	The 10 digit numeric number that has been assigned to the referring provider by CMS.
12	Referring Fax #	The fax number of the referring provider.
13	Service Start Date	The date the service is planned to be started if known.
15	Description of service being requested: Required.	A short description of the service you are requesting (examples, manual wheelchair, eyeglasses, hearing aid).
18	Serial/NEA#: Required for all DME repairs.	Enter the serial number of the equipment you are requesting repairs or modifications to or the NEA# to access the x-rays for this request.
20	Code Qualifier: Required.	Enter the letter corresponding to the code from below: T - CDT Proc Code C - CPT Proc Code D - DRG P - HCPCS Proc Code I - ICD-9/10 Proc Code R - Rev Code N - NDC-National Drug Code S - ICD-9/10 Diagnosis Code
21	National Code: Required.	Enter each service code of the item you are requesting authorization that correlates to the Code Qualifier entered.
22	Modifier	When appropriate enter a modifier.
23	# Units/Days Requested: Required.	Enter the number of units or days being requested for items that have a set allowable. (Refer to the program specific Billing Instructions for the appropriate unit/day designation for the service code entered).
24	$ Amount Requested: Required.	Enter the dollar amount being requested for those service codes that do not have a set allowable. (Refer to the program specific Billing Instructions and fee schedules for assistance) Must be entered in dollars & cents with a decimal (e.g. $400 should be entered as 400.00.
25	Part # (DME only): Required for all "By Report" codes requested.	Enter the manufacturer part # of the item requested.

26	Tooth or Quad#: Required for dental requests	Enter the tooth or quad number as listed below: QUAD 00 – full mouth 01 – upper arch 02 – lower arch 10 – upper right quadrant 20 – upper left quadrant 30 – lower left quadrant 40 – lower right quadrant Tooth # 1-36, A-T, AS-TS, 51-82 and SN
27	Diagnosis Code	Enter appropriate diagnosis code for condition.
28	Diagnosis name	Short description of the diagnosis.
29	Place of Service	Enter the appropriate two digit place of service code.
30	Comments	Enter any free form information you deem necessary.

Field	Name	Action
		ALL FIELDS MUST BE TYPED
1	**Org required**	Enter the Number that Matches the Program/Unit for the Request ~~500 - Division of Alcohol and Substance Abuse (DASA)~~ ~~501 - Dental~~ ~~502 - Durable Medical Equipment (DME)~~ ~~503 - Economic Services Administration (ESA) (DSHS)~~ ~~504 - Home Health~~ ~~505 - Hospice~~ ~~506 - Inpatient Hospital~~ ~~507 - Juvenile Rehabilitation Administration (JRA) (DSHS)~~ ~~508 - Medical~~ ~~509 - Medical Nutrition~~ ~~510 - Mental Health~~ ## 511 - Outpt Proc/Diag ~~513 - Physical Medicine & Rehabilitation (PM & R)~~ ~~514 - Aging and Disability Services Administration (ADSA)~~ ~~515 - Transportation~~ ~~516 - Miscellaneous~~
2	**Service Type required**	Enter the letter(s) in all CAPS that represent the service type you are requesting. ~~AA Ambulatory Aids~~ ~~BB Bath Bench~~ ~~BEM Bath Equipment (misc)~~ ~~BGM Blood Glucose Monitors~~ ~~BGS Bone Growth Stimulator~~ ~~BP Breast Pumps~~ ~~BS Bariatric surgery~~ ~~BSS2 Bariatric surgery stage 2~~ ~~C Commode~~ ~~CI Cochlear Implants~~ ~~CIERP Cochlear Implant Ext Repl Prts~~ ~~CSC Commode/Shower Chair~~ ~~CWN Crowns~~ ~~DASA DASA~~ ~~DEN Dentures~~ ~~EN Enteral Nutrition~~ ~~ESA ESA~~ ~~FSFS Floor Sitter/Feeder Seat~~ ~~HB Hospital Beds~~ ~~HEA Hearing Aids~~ ~~HH Home Health~~ ~~HSPC Hospice~~ ~~IPT Infusion/Parental Therapy~~ ~~ITA Inpatient admission - ITA~~ ~~JRA JRA~~ ~~LTAC LTAC~~

Field	Name	Action	
		MC	Medication
		MISC	**Miscellaneous**
		MN	Medical Nutrition
		MWH	Manual Wheelchair – Home
		MWNF	Manual Wheelchair – NF
		O	Other
		ODC	Orthodontic
		ODME	Other DME
		OOS	Out of State
		OP	Ostomy Products
		OS	Orthopedic Shoes
		OTC	Orthotics
		PAS	PAS
		PDN	Private Duty Nursing
		PHY	Pharmacy
		PL	Patient Lifts
		PMR	PM and R
		PROS	Prosthetics
		PRS	Prone Standers
		PSY	Psychotherapy
		PTL	Partial
		PWH	Power Wheelchair – Home
		PWNF	Power Wheelchair – NF
		PWNF	Power Wheelchair – NF
		PHYS	Physician Services
		R	Respiratory
		RBS	Rebases
		RE	Room equipment
		RLNS	Relines
		RM	Readmission
		S	Surgery
		SBS	Specialty Beds/Surfaces
		SC	Shower chairs
		SCAN	MRI/PET Scans
		SF	Standing Frames
		SGD	Speech Generating Device
		SSIP	Short Stay (In-Patient)
		T	Therapies (PT/OT/ST)
		TRN	Transportation
		TU	TENS Units
		US	Urinary Supplies
		V	Vision
		VNSS	Vagus nerve stimulator surgery
		VOL	Inpatient admission–Voluntary
		WDCS	Wound/decubiti care supplies
3	**Name: Required.**	Enter the last name, first name, and middle initial of the patient you are requesting authorization for.	
4	**Client ID: Required.**	Enter the client ID = 9 numbers followed by WA.	

Field	Name	Action
		For Prior Authorization (PA) requests when the client ID is unknown (e.g. client eligibility pending): • You will need to contact DSHS at 1-800-562-3022 and the appropriate extension of the Authorization Unit (See contact section for further instructions). • A reference PA will be built with a placeholder client ID. • If the PA is approved – once the client ID is known – you will need to contact DSHS either by fax or phone with the Client ID. • The PA will be updated and you will be able to bill the services approved.
5	Living Arrangements	~~Indicate where your patient resides such as, home, group home, assisted living, skilled nursing facility, etc.~~ NOT REQUIRED FOR GENETIC TESTING
6	Reference Auth #:	If requesting a change or extension to an existing authorization, please indicate the number in this field.
7	Requesting NPI #: Required.	The 10 digit numeric number that has been assigned to the requesting provider by CMS.
8	Requesting Fax#:	The fax number of the requesting provider.
9	Servicing NPI #: Required.	The 10 digit numeric number that has been assigned to the billing/servicing provider by CMS.
10	Name:	The name of the billing/servicing provider.
11	Referring NPI #:	The 10 digit numeric number that has been assigned to the referring provider by CMS.
12	Referring Fax #:	The fax number of the referring provider.
13	Service Start Date:	The date the service is planned to be started if known.
15	Description of service being requested: Required.	A short description of the service you are requesting (examples, manual wheelchair, eyeglasses, hearing aid).
18	Serial/NEA#: Required for all DME repairs. N/A	Enter the serial number of the equipment you are requesting repairs or modifications to or the NEA# to access the x-rays for this request.
20	Code Qualifier: Required.	Enter the letter corresponding to the code from below: ~~T – CDT Proc Code~~ **C - CPT Proc Code** ~~D – DRG~~ ~~P – HCPCS Proc Code~~ ~~I – ICD-9/10 Proc Code~~ ~~R – Rev Code~~ ~~N – NDC National Drug Code~~ ~~S – ICD-9/10 Diagnosis Code~~
21	National Code: Required.	Enter each service code of the item you are requesting authorization that correlates to the Code Qualifier entered.
22	Modifier:	When appropriate enter a modifier.
23	# Units/Days Requested: Required.	Enter the number of units or days being requested for items that have a set allowable. (Refer to the program specific Billing Instructions for the appropriate unit/day designation for the service code entered).
24	$ Amount Requested: ~~Required.~~ N/A	NOT REQUIRED FOR GENETIC TESTING ~~Enter the dollar amount being requested for those service codes that do not have a set allowable. (Refer to the program specific Billing Instructions and fee~~

Field	Name	Action
		~~schedules for assistance) Must be entered in dollars & cents with a decimal (e.g. $400 should be entered as 400.00.~~
25	Part # (DME only): Required for all "By Report" codes requested.	NOT REQUIRED FOR GENETIC TESTING ~~Enter the manufacturer part # of the item requested.~~
26	Tooth or Quad#: Required for dental requests	NOT REQUIRED FOR GENETIC TESTING ~~Enter the tooth or quad number as listed below:~~ ~~QUAD~~ ~~00 full mouth~~ ~~01 upper arch~~ ~~02 lower arch~~ ~~10 upper right quadrant~~ ~~20 upper left quadrant~~ ~~30 lower left quadrant~~ ~~40 lower right quadrant~~ ~~Tooth # 1-36, A-T, AS-TS, 51-82 and SN~~
27	Diagnosis Code:	Enter appropriate diagnosis code for condition.
28	Diagnosis name	Short description of the diagnosis.
29	Place of Service	Enter the appropriate two digit place of service code. **Use 11 (office) or 81 (INDEPENDENT LAB)**
30	Comments:	Enter any free form information you deem necessary.